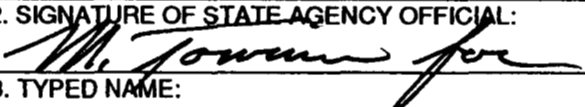
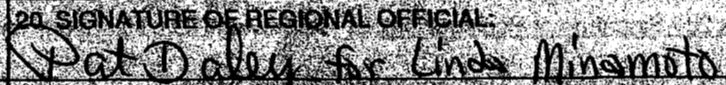


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>03-08</u>	2. STATE: Nevada
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE April 1, 2003 <del>July 1, 2003</del> PSD			
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(10)(i)(IV) of the Act		7. FEDERAL BUDGET IMPACT: a. FFY 2003 \$ None b. FFY 2004 \$ None	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to attachment 2.6A, page 1 Supplement 1 to attachment 2.6A, page 6		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 1 to attachment 2.6A, page 1 Supplement 1 to attachment 2.6A, page 6	
10. SUBJECT OF AMENDMENT: Year 2003 Federal Poverty Level			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: John A. Liveratti, Chief DHCFP/Nevada Medicaid 1100 East William Street, Suite 102 Carson City, Nevada 89701	
13. TYPED NAME: Micheal J. Willden			
14. TITLE: Director, DHR			
15. DATE SUBMITTED:			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: June 26, 2003		18. DATE APPROVED: 9/23/03	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2003		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Linda Minamoto		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS: Block 4 changed at request of State,			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

<u>Family Size</u>	<u>Need Standard</u>	<u>Payment Standard</u>	<u>Maximum Payment Amounts</u>
1	\$ 459	\$ 229	N/A
2	579	288	N/A
3	699	348	N/A
4	819	408	N/A
5	939	468	N/A
6	1,059	527	N/A
7	1,179	587	N/A
8	1,299	647	N/A

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level--

X 133 percent (no more than 185 percent)

<u>Family Size</u>	<u>Income Level</u>
1	\$ 995
2	1,343
3	1,691
4	2,039
5	2,387

TN No 03-08

Supersedes

TN No. 01-07

Approval Date SEP 23 2003

Effective Date 4/1/03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of Section 1905(p)(2)(A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official federal income poverty level:

Eff. Jan 1, 1989: 85 percent      percent (no more than 100)

Eff. Jan 1, 1990: 90 percent      percent (no more than 100)

Eff. Jan 1, 1991: 100 percent

Eff. Jan 1, 1992: 100 percent

b. Levels:

<u>Family Size</u>	<u>Income Level</u>
1	\$ 748.00
2	1010.00

TN No. 03-08  
Supersedes  
TN No. 02-07

Approval Date SEP 23 2003

Effective Date 4/1/03